

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



Vol. LXIV, No. 9

SEPTEMBER, 1960

## Calendar

### OCTOBER

- Sat. 1—On duty: Dr. G. W. Hayward  
Mr. A. W. Badenoch  
Mr. R. W. Ballentyne  
R.U.F.C. v. Trojans (H)  
A.F.C. Trial  
Tea and sports afternoon for  
Freshers (Chislehurst)  
Dean's Party
- Tues. 4—Exhibition Squash Match  
6.30 p.m.
- Wed. 5—R.U.F.C. Trial Matches
- Thurs. 6—C. U. Freshers Tea: Recreation  
Room, Charterhouse, 4.00. p.m.
- Fri. 7—Service: St. Bartholomew-  
the-Less, 1.00 p.m.
- Sat. 8—On duty: Dr. E. R. Cullinan  
Mr. J. P. Hosford  
Mr. C. Langton  
Hewer  
R.U.F.C. v. Woodford (all teams)  
A.F.C. v. Swiss Mercantile
- Mon. 10—Film Society—"The Inspector  
General"—Danny Kaye
- Tues. 11—C.U. Open Meeting: Recreation  
Room, Charterhouse, 5.45 p.m.
- Wed. 12—S.U. Council Meeting  
R.U.F.C. v. C.U. LX Club (H)  
A.F.C. v. Royal Naval College  
(H)
- Thurs. 13—Abernethian Soc. Lord Cohen:  
5.45 p.m. Great Hall: "Straight  
Thinking in Medicine"  
Squash v. Old Paulines (A)
- Sat. 15—On duty: Medical and Surgical

### Units

- Mr. G. H. Ellis  
R.U.F.C. Fixture to be  
announced
- Mon. 17—R.U.F.C. Film
- Tues. 18—Squash v. Westminster (H)
- Fri. 21—G. & S. Musical Evening,  
8.30 p.m.
- Sat. 22—On duty: Dr. R. Bodley Scott  
Mr. A. H. Hunt  
Mr. F. T. Evans  
R.U.F.C. v. Old Blues (all teams)  
A.F.C. v. North College  
(University Cup) (A)
- Mon. 24—Film Society—"The Wages of  
Fear"
- Thurs. 27—Extraordinary Meeting of the  
S.U. Council 5.30 p.m.  
Squash v. Aspro (H)
- Sat. 29—On duty: Dr. A. W. Spence  
Mr. C. Naunton  
Morgan  
Mr. R. A. Bowen  
R.U.F.C. v. Harlequins  
A.F.C. v. City of London  
College (A)

### NOVEMBER

- Tues. 1—Squash—Cumberland Cup
- Thurs. 3—A.F.C. On Tour: Cambridge
- Fri. 4—Service: St. Bartholomew-the-  
Less, 1.00 p.m.
- Sat. 5—On duty: Dr. G. W. Hayward  
Mr. A. W. Badenoch  
Mr. R. W. Ballentyne  
R.U.F.C. Cornish Tour

## Editorial

AT this time of the year we welcome to the hospital from the pre-clinical laboratories many who must eagerly have awaited the opportunity to walk the wards and watch the arts and skills of physicans and surgeons. It needs only a quick visit to some instrument maker to purchase a stethoscope before they have truly inherited the traditions of the hospital and with them those of Hippocrates and St. Luke!

Until now, exacting examiners have always made a demand for facts. There has been little tolerance of those who don't know the origin and insertion of *sartorius* or the meaning of Starling's Law. Alas, life will be very similar. However some slight hope does remain for those of us who can't remember all that we are told (for some of us will never remember the witchcraft of acid-base balance or just what Mikulicz described). This hope is experience. Above all, in medicine, no facts are useful without experience; and the importance of our clinical training lies in the blending of both. This is easy to say but it is important in explaining the inevitable repetition which will overshadow the rest of our lives. Without repetition we cannot have experience. The outlook is not so dull, though; the wisest clinician will always explain how no two cases are ever the same and how each new case is a research.

Repetition fortunately comes easily to us all. Pavlov knew this and nobody has ceased to speculate on the place of repetition since. It is always a joy to come to the chorus in a carol after fumbling through the small print of the lesser-known verses. And eventually to be able to sort the relevant facts from all the uncharacteristic ones which try to obscure a case..... It is only experience which will show us the pattern and only repetition which will make us proficient.

As we welcome so many, we lose two whose presence will be deeply missed by all. Sir James Paterson Ross and Mr. Hosford retire on September 30th. Although we will be publishing appreciations of all they have done for the hospital, any tribute would fall short of all we have received. We wish both every happiness in their new lives and are sad to lose their presence in the hospital and the wisdom of their experience.

## Fifty Years Ago

THE Journal of 1910 contains the following sketch, contributed to the writer, H. V. Wenham of the Union of the Medical College, Peking, by "A Chinese doctor of the old school".

### "A Door Case"

Yesterday, early in the morning, a tradesman of some forty years of age came to my house to ask me to see his sickness. He entered my pulse-room and said: "Sir, these few days I have been feeling a little out of sorts." I looked at his face; it was somewhat pale. I listened to his speech, it was neither clear nor free. So I asked him, saying "Do you not experience a feeling of obstruction in your chest?" "Quite right", he answered, "there is a feeling of fulness in the chest". Said I: "In my opinion, you must be a man who readily gives vent to passionate breath." "Right again", said he, "I am a little hasty tempered". "If that is the case, in the pit of the stomach on the right hand side what fashion?" The patient replied "on the right hand side there is as it were a lump which throbs continually and, moreover, it has a griping pain".

So I said to him, "Put out your left hand so that I may feel your pulse and determine what is the matter". Accordingly, after I had taken his left and right hands, and had examined the three pulses in each, I told him, "The rest of your pulses are as usual, only the right lower and middle pulses are indeed delayed and ruffled. Your sickness, Sir, is due to the depressed and gloomy breath and loss of ease".

The sick man replied: "Indeed, Sir, you are a marvellous physician! How could you, with one feel of my pulse, know all so truly?" Said I, "You had no sooner entered my room than I knew you were suffering from a little heated breath".

"Sir! how did you know that?"

"Because your face was pale; there was not a trace of colour left. Moreover, I saw that your breathing was fast and deep, and that the front of your chest was full, surely because your breath was ill at ease. So when I asked you, "In the pit of your stomach, the right side, what fashion," you told me of a lump and griping pain. I went on to feel your wrist, and discovered that the right lower and middle pulses were delayed and congealed. Then I knew that you must have been affected by the angry breath of other

men—it would be no ordinary cause—and that this sickness of yours was called 'breath depressed and ill at ease'."

"Then, doctor, bestow on me a prescription if you please." So I prescribed for him a few tastes of medicine, which would open the chest, facilitate the breath, and disperse the melancholy, using as a vehicle the lotus husks. This I gave to him, and he departed. If you wish to know whether, after eating this prescription his malady was cured or not, well! you must seek the patient and enquire of him!

The medicines employed were as follows: Orange peel, 4 drachms; aromatic bark(?), 2 drachms; orange extract (?), 1 drachm; fragrant root (*R. cypari*), 3 drachms; betel nut, 4 drachms; apricot kernels, 1 drachm; (as vehicle) lotus husks, one cupful; in water, three cupfuls. Evaporate to make half a cupful and take warm. The prescription, according to custom, was accompanied by the following note as to the prognosis of the case:

"Today, determining the character of the pulses, all are manifestly depressed and slow. This is due to constricted breath".

"The treatment should aim at opening the chest, facilitating the breath, stirring the liver, and freeing the constriction. By such means, a cure will be obtained."

### *News in Brief*

SIR JAMES PATERSON ROSS and MR. HOSFORD retire from the staff on September 30th.

The title of Professor Emeritus of Surgery in the University has been conferred on Sir James Paterson Ross on his retirement from the Chair of Surgery at St. Bartholomew's Hospital Medical College.

Theatre J in the basement of the West Wing is being converted into an Ortho-theatre, and is expected to be in service shortly.

The Squash Courts have been renovated. The season this year will open with an exhibition match by R. M. H. Boddington (Great Britain) and M. A. Oddy (Great Britain) on October 4th at 6.30 p.m.

### *Students' Union*

AT a meeting of the Students' Union Council held on August 10th, 1960, with Mr. A. H. Hunt in the chair, the chief topic of discussion was the draft of a new Constitution for the Students' Union. The main points of this draft had been introduced at the previous Council meeting and it was considered clause by clause. After suitable amendments had been made it was decided to present the new Constitution for ratification at an Extraordinary General Meeting of the Students' Union to be held on October 27th, 1960.

Student facilities in the Hospital were discussed with special reference to the Rifle Club's recent loss of the miniature range (required by the Hospital for the storage of notes). The Rifle Club pointed out that they wished it to be known that they were concerned at the loss and did hope for assurance that an alternative site could be found in the future.

### *Lectures*

Dr. Alvin F. Coburn of New York gave a lecture on Tuesday, Sept. 27th at 5.30 p.m. at the Medical College, Charterhouse Square. He spoke on "A New Concept in the Mechanism of Rheumatic Fever".

At 3.15 p.m. on the same day Dr. Coburn addressed students on "The Use of Adversity and the Pathogenesis of Rheumatic Fever".

### *Film Society Programme*

- October 10—"The Inspector General".
- November 7—"High Society".
- 21—"Jour de Fêtes".
- 24—"The Wages of Fear".
- December 5—"Scott of the Antarctic".

### Appointments

DR. J. H. GALBRAITH—Medical Tutor from 1st August, 1960.

DR. M. A. BEDFORD—Lecturer in Anatomy from 1st August, 1960.

DR. D. W. DOWNHAM—Junior Lecturer in Anatomy from 1st September, 1960.

DR. E. P. W. TATFORD—Junior Lecturer in Anatomy, from 1st September, 1960.

DR. J. T. SILVERSTONE—Junior Registrar to Dr. Cullinan, from 1st October, 1960.

DR. B. P. HARROLD—Junior Registrar to the Medical Professorial Unit, from 1st September, 1960.

MR. B. MEASDAY—Resident Assistant Physician Accoucheur, from 1st April, 1960.

DR. H. W. BALME—Sub-Dean of the Medical College, from 1st September, 1960.

### Examination Results

#### UNIVERSITY OF LONDON

##### *Ph. D. Examination (Faculty of Medicine)*

Bergel, D. H.

##### *Special Second Examination for Medical Degrees*

##### **July 1960**

Abayomi, I. O.  
Brewer, C. L.  
Davies, W. A. M.  
Littlewood, P.  
McPhail, L. M.  
Newstead, F. B.  
Sibunruang, S.  
Wan Ping, I. H.  
Benison, R. S.  
Cannon, J. P. G.  
Evans, J. P.  
Lloyd, C. M.  
Miller, A. J.  
North, P. J.  
Stephenson, T. P.  
Ying, I. A.  
Bousfield, J. D.  
Challis, J. H.  
Frank, A. J. M.  
McLaughlin, J. E.  
Nash, A. V.  
Savege, P. B.  
Tandy, W. R.

ROYAL COLLEGE OF SURGEONS.—*F.R.C.S.*  
J. N. Cozens-Hardy.

### Engagements

BELL—LONG.—The engagement is announced between Dr. Thomas John Cranston Bell and Dr. Daphne Nevill Long.

O'KEEFE—BASS.—The engagement is announced between Dr. Charles James Maunsell O'Keefe and Joy Bass.

SIBSON—LANGTON.—The engagement is announced between Dr. Derek Edmund Sibson and Elizabeth Jane Langton.

### Births

BIDDELL.—On July 30th, to Sheelagh, wife of Dr. Paul Biddell, a son (Hugh John).

CAIRNS.—On August 3rd, to Valerie and Dr. David Cairns, a daughter.

CARR.—On July 31st, to Audrey, wife of Dr. Conor Carr, a son (Nicholas John).

CHAMBERLAIN.—On April 5th, to Drs. Jennifer and Douglas Chamberlain, a daughter (Mary Ann).

GARROD.—On August 2nd, to Gwyn, wife of Dr. D. C. H. Garrod, a fourth son.

MOLESWORTH.—On July 28th, at B.P. Refinery Hospital, Aden, to Rosemary Ann and Dr. Peter R. H. Molesworth, a son (Nigel Piers Henderson) a brother for Simon and David.

TABOR.—On August 17th, at R.A.F. Hospital, Akrotiri, Cyprus, to Shiona, wife of Flg. Offr. A. S. Tabor, a daughter (Mary Claire).

### Deaths

GRAETZ.—On August 16th, Dr. Gerhard Herman Arnold Graetz. Qualified 1929.

GRANT.—On August 20th, Col. M. F. Grant (Late R.A.M.C.), aged 82. Qualified 1904.

HEATH.—On July 31st, Surg. Captain George Edwin Heath, R.N., aged 70. Qualified 1916.

LITTLEJOHN.—On August 4th, suddenly in Melbourne, Victoria, Dr. Charles Littlejohn of a coronary attack. Qualified 1914.

PEARCE.—On August 6th, Cyril Morgan Pearce, F.R.C.S., aged 61. Qualified 1923.

RICHMOND.—On August 11th, Dr. Arthur Richmond. Qualified 1902.

WILLIAMS.—On August 8th, The Very Rev. Frank Garfield Hodder Williams, aged 78, Dean Emeritus of Manchester. Qualified 1908.

ROBERTS.—On May 27th, Coral Roberts, widow of J. E. H. Roberts, O.B.E., F.R.C.S.

## Marriages

BLOOMER—GILMOUR.—On July 27th, Dr. A. C. S. (Mike) Bloomer to Judith H. Gilmour.

EDWARDS—BINGHAM.—On August 12th, at St. Bartholomew's-the-Great, Dr. J. Griffith Edwards to Dorothea M. A. Bingham.

## Change of Address

Dr. A. M. Pocock (née Tressidder), 59 Purewell, Christchurch, Hants.

## A CASE OF NEGLIGENCE?

*From an article by R. M. S. McConaghey, Medical History, Vol. I, No. 2, April 1960*

THE Medical Records of Dartmouth, 1425-1887, give an interesting account of practice in the 19th Century. Under the Poor Law Amendment Act of 1834 the chief reform was to unite groups of parishes into unions administered by guardians. Each union appointed medical officers to several districts under their control who gave medical attention to poor parishioners. There were inevitable disputes between the guardians and the commissioners of His Majesty's Government about the running of the unions.

One dispute was related to John Morgan Puddicombe who was either in partnership with or assistant to his father. He had studied at St. Bartholomew's and achieved his M.R.C.S. in 1837 and his L.S.A. in 1838. The evidence of Puddicombe gives an intriguing picture of the methods of practice in those days. A pauper had met with an injury in the middle of the night . . .

"The noise he made alarmed a gentleman living near the spot. On finding what had occurred and that the man was unable to move, owing to a fall from a considerable height, he ran to the nearest surgeon, and soon returned with my brother, a young man now serving his apprenticeship with my father, the latter being indisposed, and not able to attend. Finding themselves insufficient to remove him to a place of safety, they, with some difficulty, in consequence of the lateness of the hour, obtained the assistance of two men, and carried him to the poorhouse, in the parish of Townstal, where he was placed on a kind of bed, and left until morning when I was sent for to attend him; on my arrival I found a considerable shortening of the left leg, with the foot turned over to the right tibia, at about the commencement of the lower third; combined with this was tremendous swelling of the muscles about the hips and thigh, so much

so, that at my first visit the cause appeared so intricate and the pain the man suffered so intense, that I hardly knew how to act; I remained with him about twenty minutes, and after making gentle extension for a short time, the foot suddenly resumed its natural position; at this time the hip and thigh were at least double their natural size, and still remained so after this operation. On my next visit I found still considerable swelling and pain, which continued for many weeks; the patient was unable to move from the position in which he was placed. Mr. Paige and myself with the assistance of the two overseers of the parish, with considerable difficulty removed him from the bed to a chair placed beside it, his bed was then made up for the first time since the accident, and he returned to it after remaining out a short time. About three weeks after this I stated he might be safely removed to the union house."

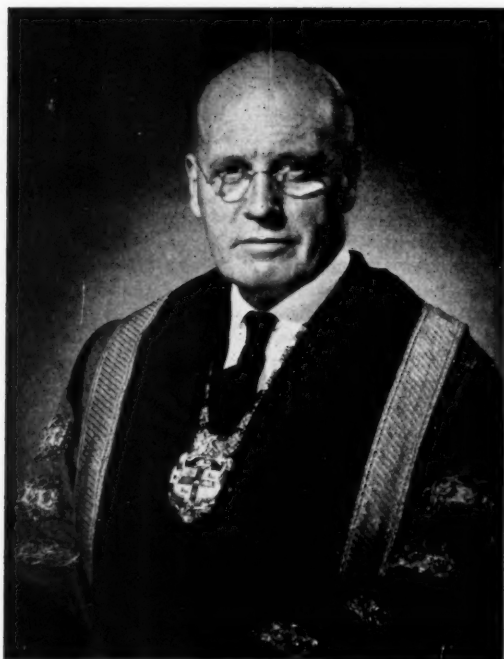
In the enquiry about the case the chairman of the board of guardians stated:

" . . . that he (the doctor) never used a pulley or any other instrument to replace the dislocated bone; that he neither gave him any kind of lotion to strike it with, nor did he give any medicine; that he only felt the thigh, and I think said attended him but once . . . Again in the parish of — I am informed that the same medical man was called to a case of midwifery, and attended it for a week or a fortnight, and then finding the woman incapable of paying the amount incurred, applied to the overseer of that parish for an order" . . .

Despite this unfortunate incident Puddicombe became an influential and respected citizen of Dartmouth; he was three times mayor and was elected alderman. Perhaps his practice wasn't so much at fault after all!



## *Sir James Paterson Ross*



*By permission of the Royal College of Surgeons*

**P**ROFESSOR Sir James Paterson Ross, Bart., K.C.V.O. was doomed to retire from the staff of the Hospital on May 26 when he reached his sixty-fifth birthday—nominally, that is—his retirement does not in fact take effect until the end of September. This might be called a milestone on the journey of a professional man through life, but it is also a kind of tombstone, and an appraisal of what the Hospital is losing is almost an obituary. We are sad to lose him, and he, we may be sure, is sad to go. It is true he will become a Consulting Surgeon, but that is a title, not an occupation; it is part of the inscription on the tombstone.

Sir James was born in Hornsey, North London, and was schooled at Christ's College, Finchley. He entered St. Bartholomew's Hospital Medical College in 1912 at the age of 17, and from the start was a winner of academic distinctions. His childhood had been passed mainly in London, but holidays were spent running wild on his grandfather's farm in the north of Scotland. Sir James is unmistakably a Scot—he never refers to his friends without the prefix Mr. until he has known them for quite a number of years. He recalls that his home life was simple, but filled with a sense of security and happiness. This tended to make industry and a sense of

duty come to him naturally, as was reflected in his College and Hospital career. At the end of his first year he won the entrance scholarship in science. At that date no undergraduate was registered as a full student until he had started work on anatomy, so that it was still possible, while working on the preliminary sciences, to win an entrance scholarship. In the following year he won the Treasurer's Prize and the junior scholarship in Anatomy and Physiology. Though never a notable athlete, he represented the Hospital at cricket and hockey. In August 1914 he returned from a holiday in Scotland to find himself, by virtue of being a member of the O.T.C., "directed" by Sir Wilmot Herringham to the 1st London General Hospital, where, after a brief course of dispensing at Bart's, he served as a Sergeant Dispenser until February 1915. In March he was demobilized and was allowed to return to Bart's to begin his clinical studies. He obtained the qualification of the Conjoint Board less than two years later in January 1917.

Sir James had been dresser on the firm of Cozens Bailey and Girling Ball, and it was the example of Bailey which turned his mind to surgery as a career. Both his chiefs were also popular teachers. In those abnormal times the "house job" was curtailed to three months and, despite his inexperience, the young house-surgeon had to take regular teaching sessions too. His choice for war service had fallen on the Navy, and in May 1917 he went to Haslar Hospital, going to sea a few months later in the light cruiser "Celedon". After the armistice he was transferred to the "Baltic" and was not released until October 1919.

Sir James confesses that, although not a warlike type, he thoroughly enjoyed his naval service and has liked to remain in touch with his shipmates through membership of the Royal Navy Medical Club. Surgical experience on active service was necessarily limited; yet he has felt, as have so many others, that the wider view furnished by service life has been an asset for which he has always been grateful. Nevertheless he was able to return with zest to more academic surroundings at Bart's and was at last able to take the London M.B., B.S. in May 1920, gaining distinction in surgery and the University Medal. He had done much reading in surgery while at sea, and gained extra

medical knowledge by working as clinical assistant to Dr. (later Sir) Arnold Stott at the Royal Chest Hospital, City Road. After working as junior Demonstrator of Physiology under Professor Bainbridge he passed the Primary F.R.C.S. examination and then moved over to the department of Pathology under Professor Sir Frederic Andrewes. It is almost a satisfaction (and an encouragement to others still engaged in the battle of life) to be able to record that Sir James *failed* in the final F.R.C.S. in November 1921. Nevertheless Professor George Gask, head of the first professorial surgical unit to be established in London, had his eye on the young surgeon and enabled him to do a *locum* on the unit early in 1922. In May he defeated the examiners at the Royal College (he won the degree of M.S. London in 1928). Nine months work in the Pathological Department followed, and then came one of the most formative periods of Sir James's life—six months as Associate in Surgery at the Peter Bent Brigham Hospital in Cambridge, Massachusetts, under Harvey Cushing. The object was to gain experience in neuro-surgical technique under its greatest exponent, but Sir James profited also in many other ways. Cushing treated him almost as a son, and he obtained an intimate view of life in New England. He visited many other clinics from Chicago to Washington, and, of course, the Mayo Clinic. There were no travelling Fellowships in those days, and the savings out of naval pay had to be sacrificed. He returned home in September 1923 to take up an appointment as Junior Chief Assistant on the Surgical Unit. Earlier in the year T. P. Dunhill had joined Gask as Assistant Director, and he now became one of the major influences in Sir James's life. "Respect for tissues" has always been one of his first principles in surgery, and he likes to attribute this to having worked with Cushing and Dunhill.

Meanwhile he had been working for part of his time at the National Hospital for Nervous Diseases, Queen Square, and this fitted in well with Gask's growing interest in the surgery of the sympathetic system. Together they gave great attention to the problems of sympathetic control of the vascular system. Professor Woollard helped in the anatomical studies which had to precede the surgical treatment of conditions such as Reynaud's disease, causalgia following the many nerve injuries sustained during the first

World War, and the many obscure vascular anomalies thought to be due to disorders of the sympathetic system. It was a new field for surgery, and demanded profound knowledge of physiology as well as of anatomy; the clinical material collected over several years provided the basis for the Jacksonian Essay, which gained the prize in 1931. In the same year Sir James gave his first Hunterian Lecture at the Royal College of Surgeons on the treatment of cerebral tumours by radium. He gave two more Hunterian Lectures in later years on "Sympathectomy as an experiment in human physiology" (1933) and on "The effect of radium on carcinoma of the breast" (1939). He was also co-author with Gask of a monograph on *The Surgery of the Sympathetic System*, published in 1934.

In 1931 Sir James had been appointed Assistant Director of the Surgical Unit, in association with Dunhill, and University Reader in Surgery, and in 1935, on Gask's retirement from the Chair of Surgery and from the staff of the Hospital, he was the obvious successor. It had always been recognized that Dunhill would not succeed Gask, but would retire simultaneously from the Unit, so that there was no embarrassment for anyone when Gask was followed immediately by his junior Assistant Director.

Sir James had never had any doubt about his preference for the academic life and had seen little of the more worldly side of surgery in private practice—indeed, his only experience of this was as one of the assistants employed by Dunhill and by Lord Moynihan of Leeds when he operated in London at Lady Carnarvon's nursing home in Portland Place. All this activity, together with his chances of doing further laboratory researches, ended with his appointment as Professor of Surgery. Henceforth he was compelled rather to direct the work of others, and even this role was shattered after less than four years by the outbreak of the second World War. As Sir James has said, the Unit disintegrated at the end of 1939 as completely as if it had received a "direct hit". He moved to Hill End where he was in charge of eighty beds and was responsible with Professor Christie for directing the clinical studies of all the Bart's students during their first nine months. He also organised for the Emergency Medical Service the neurological casualty service in all the London sectors north of the Thames and later

in a large area embracing all the Eastern Counties. Other war duties were membership of the War Wounds Committee, investigation of the cross infection of wounds in hospitals, and a tour with Howard Florey in 1940 to see all the experimental work being done in the United Kingdom on the healing of wounds. Sir James also found time to look after a centre at Hill End for treating wounds of the blood vessels. This enabled him to collect some original observations on sixty patients with arterio-venous fistulae. His hands were more than full, since he filled also the posts of Consulting Surgeon to the King Edward VII Convalescent Home for Officers at Osborne, and to the Papworth Tuberculosis Settlement.

With the end of the war Sir James was at length able to return to Bart's to resume the professorial duties which he has performed with so much distinction during the last fifteen years. Even so he was not allowed to carry this through without interruption. He had been elected to the Council of the Royal College of Surgeons in 1943 and was persuaded, though very reluctantly, to accept the office of President in 1957, being re-elected for the next two years. Sir James is the least self-seeking of men, and his reluctance to accept presidential office was increased by his wish not to neglect his hospital and teaching duties during the last three years of his professorship. But his personal distinction was such that there was no escape. His quiet efficiency had not, it is true, brought him conspicuously into the public eye, until, on Sir Thomas Dunhill's recommendation, he was chosen to collaborate with Sir James Learmonth in bringing King George VI in March 1949 through the serious operation of lumbar sympathectomy to counteract an incipient gangrene of the foot. King George showed his appreciation of the skill and care he had received when, during his convalescence, he unexpectedly commanded his surgeon to kneel beside his bed to be dubbed a Knight Commander of the Victorian Order. There is no other recorded instance of a knighthood having been conferred by a monarch clad only in pyjamas. At a later date Sir James collaborated with Dunhill in operating on Sir Winston Churchill, an exacting patient who insisted on understanding for himself the precise reason for everything that was to be done. After the death of King George Sir James was appointed surgeon to H.M.



the Queen. In the early part of 1957 he visited many medical centres in Australasia as Sir Arthur Sims Commonwealth Professor.

Despite his modesty Sir James has conferred distinction on his Hospital throughout his career. He has not been a prolific writer, but he shared with the late Sir Ernest Rock Carling the great task of editing the eight volumes of *British Surgical Practice*, published in the years 1947 to 1950, with annual supplements to date.

This is all of a piece with his general character as a surgeon and teacher. Being convinced of the paramount importance of putting diagnosis far before everything else, he takes every possible care in examination of a patient and in clinical investigation. As a diagnostician he is much better than "brilliant"—he is infinitely careful and logical and allows students to hear his mind working towards the desired end. As a technician he is correspondingly careful and gentle, and his colleagues have not infrequently paid their tribute to his qualities by unhesitatingly committing their bodies to his competent hands. His patients have always known instinctively that implicit trust could be placed in his integrity, judgment, and common sense. His students have felt that he is their friend and mentor—in fact, little as Sir James may like to see it down in print, he has established himself at Bart's as what psychologists sometimes call a "father-figure" and

he will be missed to a corresponding degree when he has left the active staff.

It was no surprise to anyone and a satisfaction to everyone when Sir James figured as a baronet in the Honours List last year. He does not retire into idleness, having been appointed successor to Sir Francis Fraser in the office of Director of the British Postgraduate Medical Federation. Sir James will naturally protest that he owes much of his distinction to the education and companionship he has received at his hospital—and indeed no one will deny that he does have to acknowledge at any rate one great debt to Bart's. In 1924 he married Miss Marjorie Townsend, a sister in one of Professor Gask's wards, and their two sons, Keith and Harvey, are carrying on the Ross tradition, one having been educated at the Middlesex Hospital and the other at Bart's.

Sir James does not shoot or fish or do any of "the other things that gentlemen do", as he puts it: His tastes are simple and nothing delights him more than a cross-country walk. It has long been one of his ambitions to walk along the whole of the Pilgrim's Way—he has accomplished so far no more than the stretch from Winchester to Dorking. But his pilgrimage is not yet over and he and Lady Ross carry with them on their way the affection and good wishes of all students and colleagues who have been privileged to know them during the past thirty-five years.

St. Damian

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**M**Y first memories of Sir James Paterson Ross and of the unit, date from that period just at the end of the war when a great deal of change was taking place. I first came as a visitor. I was still in the Air Force and had charge of a Vascular Unit and wanted to learn as much as I could that might help to improve it. Professor Paterson Ross at Bart's and Professor Learmonth in Edinburgh had been the pioneers in this type of work in Britain and their units were the places to go to learn new things in vascular surgery. No secrets were kept and I, like many others, found valuable help and advice. The unit was a hive of activity in all sorts of ways and many changes were going on. On its staff at the time were Rundle and Lowenthal, now both professors in their native Australia, Walker who is now in Canada, and Longland who later crossed the

border in an unconventional direction to take charge of a large surgical unit in Scotland. Professor Boyd of Manchester, an ex-assistant director, used to visit from time to time always with unusual and original ideas which provoked argument and intellectual stimulus although they did not invariably gain complete acceptance. Robertson, one of the leading surgeons in Sheffield, and Tuckwell and Nash also worked on the unit in the period after the war.

At the head of all this change and development and keeping it all together and running efficiently was Sir James. Naturally he was in great demand. Not only did he have the normal load of surgical responsibility and teaching (and he was reputed to be the best undergraduate clinical teacher in London) but his opinion was sought in committees and endlessly on individual problems in

this period. It was only by his great industry and ceaseless activity that all the demands were met and the ground covered. I remember two members of the unit discussing the Professor's problems and the problem of catching him for a discussion on some point. "The Professor is so busy now that you have no hope of catching him for a leisurely half an hour", it was said. "Your best plan is to walk rapidly beside him as he moves from his office to some assignment elsewhere. You will then be able to discuss your problem as you move along. There is, however, one warning sign to observe. Should the Professor be moving so fast that the tails of his white coat are extended horizontally behind him, it is better to desist and to seek an opportunity to raise the matter on a more favourable occasion." The advice and help that were rendered were in fact so good and so willingly given that the demands became almost greater than one human could fulfil in each twenty-four hours of a day.

It is most remarkable to realize that all

I AM grateful to the Editor for giving me the opportunity of paying tribute to Sir James Paterson Ross. Although it is always difficult for the living to write about the living, it is imperative that on the occasion of his retirement from the Chair of Surgery at Bart's there should be some printed expressions of the respect and affection in which he is held by his colleagues.

It is I think germane to bear in mind that his career has occupied approximately the second quarter of the twentieth century, a period during which great advances have been made in medicine as a whole, and notably in those basic sciences which contribute to diagnosis and therapeutics—including surgical therapeutics and all that this term has come to include. During this period Paterson Ross has held a number of great offices, and happily will continue to hold certain of these; and he will add others to his responsibilities. He has been one of the first to direct a Department of Surgery as a whole-time Professor; he has been President of the Association of Surgeons of Great Britain and Ireland; he has been a distinguished and always welcome ambassador of British surgery in many lands; he has been President of the Royal College of Surgeons of England. His own exceptional qualities exercised in these positions gave him the opportunity of profoundly influencing British

this work was done at Bart's and that at the same time Sir James undertook and brought to success great tasks at the Royal College of Surgeons and at the University.

Later I had the good fortune to work for a number of years with Sir James on the unit. It was one of the most pleasant and fruitful periods in my surgical lifetime. I know that there are very many others who feel the same and who realize that it was his work and help that really made everyone else's efforts of value and which made the unit at Bart's a fine example to other schools.

The University of London and all of us who are interested in postgraduate medical training, as well as the younger men who are going to do it, are indeed fortunate that we shall have Sir James as Director of the British Postgraduate Federation. We congratulate ourselves on our good fortune and wish him well in this new task which he takes up on his retirement from the Chair at St. Bartholomew's.

John Kinmouth

surgery, and I suspect that his object has been to arrange a harmonious fusion between the newer scientific surgery and the older art of surgery—a union seen at its best in the last edition of his book on the surgery of the sympathetic nervous system.

What are the exceptional qualities his colleagues have recognised in Paterson Ross, which enabled him to exercise so good an influence on surgery? Of course he has all the ordinary ones—industry, clinical judgment, technical skill. I would place first that he has always been himself: never spectacular, influencing by example rather than by precept, making his points by demonstration rather than by proclamation. A direct result of being himself has been his power of making lasting impressions upon people he meets—a power said by Sir Winston Churchill to be one mark of a great man. For the other qualities I cannot do better than go back six hundred years to Guy de Chauliac and his notion of what a surgeon should be: "Bold in those things that are safe, or that he can safeguard by his own judgment and experience; prudent in those that are dangerous; avoiding all evil methods and practices; tender to the sick, honourable to the men of his profession; truthful, wise in his predictions; chaste, sober, pitiful, merciful, not covetous nor extortionate."

James Learmonth

## THE QUESTIONNAIRE

### General Practice

by J. T. Silverstone

#### Numbers

"Do you want to be a General Practitioner?" "Yes, definitely", answered 17. "Probably", answered a further 127. Thus it would appear 144 students (38 per cent) wished to take up General Practice. Yet, to confuse the statistician, when asked which branch of medicine they wished to enter, only 107 selected General Practice from a list of five including medicine, surgery, midwifery and "other". I propose to limit the discussion to the 144 who probably want to become general practitioners, assuming that this number includes the 107 who "wish to enter general practice", ignoring the semantic niceties which have obviously been important to at least 37 who answered differently to questions 18-21.

In the country as a whole during 1958 there were 90,692 doctors on the register, of whom 20,295 (22 per cent) were principals and 1,394 (1.5 per cent) were assistants in general practice. There were 1,911 doctors qualifying in England and Scotland who were newly registered in 1958. In the same year 1,062 became principals in general practice. Although no firm conclusion can be drawn from these last two figures, they would indicate that over a period about 50 per cent of newly qualified doctors will become principals in general practice.

Thus the Bart's figures seem to be only slightly at variance with the national trend.

#### Background

Of our 144 enthusiasts, 120 were men and 24 were women, i.e. a slightly higher proportion of women (2 per cent). 33 of the total had been to Grammar School and 93 to public school; the proportions are 29 per cent of all those from grammar schools and 40 per cent from public school, a slight indication that public schools provide more aspiring G.P.'s. When considering previous university education, we have to select only clinical students, 8 (40 per cent total) Oxford alumni elected for general practice, whereas 35 (50 per cent total) from Cambridge so

elected. Proportionally even fewer of those clinical students who have crossed Smithfield Market from the green fields of Charterhouse wish to become G.P.'s—45 (35 per cent total).

Whether due to the influx of would-be G.P.'s from Cambridge or not, there were proportionately more clinical students than pre-clinicals who preferred general practice. By years, the figures are: Pre-clinical 1st year—8 (20 per cent), 2nd year 20 (33 per cent), 3rd year 18 (25 per cent), clinical 1st year 28 (35 per cent), 2nd year 29 (45 per cent), 3rd year 26 (42 per cent).

Perhaps more decisive in a student's choice is his family background. Of the 144 inclining towards general practice, 79 had a relative who was a doctor. But the total number of students with relatives as doctors form a much smaller proportion of the total number. Those with more intimate knowledge of medical life tend therefore towards general practice; more than those coming into the profession with perhaps a more naive outlook. Yet of those with medical family associations, only 55 (32 per cent) have an opportunity to join a given practice. These figures are not strictly comparable as the 79 with relatives in the profession are selected from those wishing to enter general practice, whereas the 55 with a given opportunity in general practice relate to the total number of students. It is still valid to comment that a student with a medical background is not necessarily going into general practice because there is a partnership waiting.

One supposes that general practice would offer more security than a speciality. One might also suppose that those who are engaged and married would be concerned particularly with security. Yet of those engaged (37) only 16 opt for general practice and of those married without children (15) only 5 opt for general practice. More strikingly not one of 7 students with children seek the "security" of general practice. Perhaps the presence of children in the home encourages the fathers to continue in resident jobs as long as possible!

One sobering fact to emerge is that of all those wishing to do general practice 80 (more than half) had not spent even a day observing or assisting a general practitioner. Is this a reflection on the students for not trying to broaden their outlook, or a reflection on the College authorities for not providing adequate experience?

### *Reasons*

Seven possible advantages of general practice were listed in the questionnaire. Students were asked to mark those which influenced them in their choice of general practice as a career and which was the most important. If the dominant reason was not among those listed, they were asked to state it.

Here is the list in order of importance to students, with the number of prospective G.P.'s who gave this as their most important reason for wanting to be a G.P.

- (a) Responsibility for the health of individuals from birth to grave (23);
- (b) Diagnosis and treatment of a greater variety of complaints (20);
- (c) Too much competition and uncertainty of becoming a consultant (16);
- (d) Opportunity to join a given practice (14);
- (e) Mental capacity not suited to specialist practice (11);
- (f) Important role in the social life of your community (10);
- (g) Better early financial rewards (5).

Several (26) appeared not to answer this question and 19 wrote an alternative reason. The most popular alternative reason was "Getting to know and help people"—the others fell broadly under the headings already given.

It would seem that 43 wanted to be a G.P. from a positive desire to practice the type of medicine that can be practiced only by the family doctor. However, rather more (56) preferred general practice for no positive virtue in the calling—35 of them were hard-headed realists who felt they could not make the grade in specialist medicine, or those who were not going to give up a ready-made opening or those who were going for an immediate living wage with home life, rather than live the monastic life of a junior hospital doctor.

While several of these realists might well have been very happy to enter general practice even if they could climb the ladder of

specialist medicine, we must assume honesty and reliability when they tell us their most important reason.

Their colleagues who aim to specialise have rather different feelings. They appear to be a timid lot for if they were to enter general practice the factor that apparently inclines them towards it most is the competition and uncertainty of specialist practice.

### *Type of practice*

Fifteen (10 per cent) wanted to "go it alone" in a single-handed practice; 57 preferred a partnership, of which 52 preferred a true group practice in which each partner spent some time in specialist work within the practice. When we remember that less than half those selecting a given type of practice have any idea what they are choosing, the figures take on an air of unreality. The competition for each single-handed vacancy is still intense—there were 184 vacancies in 1958 for which there were 5,735 applications, an average of 31 applications per vacancy. This application/vacancy ratio was 35 in 1957, 43 in 1956 and 44 in 1955. The equivalent figures for partnership applications are probably higher.

If the preferences of Bart's potential G.P.'s could be met, the cities would be suffering a severe shortage of doctors. Only 12 (10 per cent) wished to practice in the city, while 66 (50 per cent) wanted to settle in the country. 48 (40 per cent) thought they might get the best of both worlds by practicing in a town. What actually happens to the 68 per cent of doctors who are partners in general practice is as follows: 35 per cent practice in urban areas, 40 per cent in semi-urban and 25 per cent in rural areas.

It would appear from the Ministry of Health's report that a greater proportion of the partnerships in the urban areas consist of two or three doctors (94 per cent) than in the semi-urban (86 per cent) and rural areas (85 per cent).

Again the 144 students were preponderantly in favour of the southern half of England. 51 were for the South, 24 for the West country and 15 for East Anglia. Only 10 each were for the Midlands and the North, 8 for Wales and 6 for Scotland.

The Ministry of Health reports that in 1958 there were 13,253 doctors in partnership—about half of these were in two-man



partnerships and a quarter in three-man partnerships. Larger practices were much more uncommon. During this year there were 6,346 (32 per cent) in single-handed practices.

The trend seems to be away from single-handed practices, for in 1956, 18.9 per cent of doctors who were under 35 were in single-handed practices as compared to 50 per cent of those over 66, in 1958 only 18 per cent of those under 35, as compared with 45 per cent of those over 66 were in single-handed practices. It would seem that the figure of 10 per cent of those at Bart's who want to enter single-handed practice is a reflection of this trend towards more partnerships.

## Conclusion

We can now create the image of the "typical" Bart's prospective G.P.

He is the product of the Public School and Charterhouse Square with medical connections in the family but no opportunity to join a given practice. He has never seen a G.P. at work yet knows he wants to treat his patients from birth to grave in a country practice in the South of England. Good luck to him.

## Reference:

*Report of the Ministry of Health for year ended 31st December, 1958.*

# GASTROSCOPY

by Peter Knipe

**E**NDOSCOPY is the art of direct visualisation of body cavities and is widely employed in medicine. Gastroscopy is one method of endoscopy which has lagged behind in general acceptance, although most of the technical difficulties were solved in 1932 with the introduction of the flexible instrument. As one of this country's foremost experts (Avery Jones) is a Bart's man it would seem appropriate that we should study the art. It is unfortunately the most difficult of endoscopic studies, not only in its technique, but also in the interpretation of the findings.

## History

Kussmaul in 1868 was the first to attempt to see the stomach cavity directly, although a Dr. Campbell in Glasgow some years earlier had asked a professional sword swallower if he would act as a "guinea pig". The man is reported as saying in refusal "I know I can swallow a sword, but I'll be . . . if I can swallow a trumpet". Nitze in 1879, after solving the problems of illumination in his cystoscope, turned his attention to gastroscopy and was probably the first person to see recognisable gastric mucosa. A flexible instrument is needed for vision of the whole interior, and therefore has its own special problems of intricate lens sys-

tems. The discovery by Schindler and Wolf in 1928, that it is possible to see through a curved tube with lenses of short focal length, finally saw the rigid tube discarded in favour of a flexible one; and their introduction in 1932 of the flexible gastroscope heralded a wave of popularity for gastroscopy. This instrument is still in use, though it has the disadvantage of possessing many blind spots. Hermon Taylor in 1941 introduced an instrument with a flexible tip which could be actively moved. This largely superseded the Schindler gastroscope in this country. But gastroscopic blind spots, coupled with the progressive increase in quality of diagnostic X-rays, and the undoubted necessity for skilled training as a gastroscopist, have held back general acceptance of the procedure.

## The Instrument

The Wolf-Schindler gastroscope, 78 cms. in length, has a distal half (approx.) as a flexible steel coil with a rubber jacket terminating in a bulb and a solid rubber tip (see Fig. 1.) The proximal part is a rigid steel tube ending in an eyepiece with a balloon attachment and flex. The interior contains an optical lens system, surrounded by an air jacket. With this instrument, even when the eyepiece is introduced to the teeth, the junction of flexible with rigid parts is



still at least 3 cms. above the cardia. The Hermon Taylor instrument (see Fig. 1.) is similar in principle, but the flexible portion is sheathed by two concentric metal springs with left and right handed thread, and movement is controlled by two straight wires to a rack and pinion by a push-pull action. Although this affords controlled movement of the tip and thereby eliminates many blind spots, it means the flexible length has to be reduced, and this brings the flexible-rigid junction through the dangerous angle of the cardia. Both instruments have right-angled vision with an angle of vision of approximately 50 degrees.

### *Technique*

As with all other medical investigations, it is essential that the patient has confidence in the gastroscopist, and one should always explain simply the reason for, and basic steps of, the procedure. Examination should be made of the teeth, and the possibility of kyphoscoliosis or cervical osteoarthritis should be considered. Other examinations for heart size, and possible oesophageal varices are made. Barium meal X-rays should be available for study before gastroscopy (though there are exceptions to this rule) in case there should be oesophageal or hiatal obstruction. The patient should have nothing to eat or drink since the previous evening, and with the out-patient it is desirable to pass an oesophageal tube immediately before gastroscopy to empty the stomach content. This procedure should also be carried out on a patient with pyloric stenosis or suspected carcinoma of the cardia. One hour before instrumentation, he is given a routine premedication, and half an hour before, half a tablet of Decicaine to suck. The patient is then brought into the darkened examination room. His position on the table is of great importance. The left lateral position with the knees drawn well up to the chest and the back rounded, is the correct one. The left hand is under the right axilla and the right arm is allowed to hang down over the edge of the table. The left shoulder should be at the top of the table so that the head rests over the top, in the palm of the assistant's left hand, and the patient should be encouraged to relax. The head should then be completely flaccid and moveable without any force by the assistant, who with his right hand on the right side

of the head has precise control.

The gastroscope is then introduced with three basic movements (see Figs. 2, 3). With the patient's head fully flexed on to the chest, the surgeon stands opposite the patient's chest, holding the gastroscope by its flexible portion in his right hand, a second assistant taking the weight at the eyepiece end. In the first movement the surgeon's left index and middle fingers are passed over the patient's tongue, the thumb sweeping the upper lip away from the upper teeth to prevent it being caught by the instrument. In the second movement, the rubber tip of the instrument is passed along the dorsal aspect of the index finger, the third finger is crooked over it, thereby angulating it sharply downwards. The gastroscope throughout this procedure is pointing upward in the direction of the naso-pharynx. In the third movement, two things are achieved as one combined movement. The tip of the instrument, protected by the third finger from the posterior pharyngeal wall, is advanced through the crico-pharyngeus, and at this precise moment the right hand is moved back to take the rigid portion of the instrument, and with it to describe an arc, bringing the eyepiece from a plane at right angles to the body into the axis of the oesophagus. Synchronously with this movement, the first assistant extends the head as the instrument is advanced swiftly but with meticulous gentleness into the stomach. The crico-pharyngeus may offer an obstruction, but if the patient is asked to swallow, this is easily overcome, and any use of force is absolutely contraindicated.

When the examination is completed, the patient is sat up for a few moments and encouraged to bring up wind before being moved to an adjacent room where he sleeps for an hour or two, after a brief question about any pain or dysphagia, and palpation of the root of the neck by the surgeon the patient is allowed to begin taking liquids and light foods, and then return to normal.

### *Orientation*

The principal factors discouraging endoscopists are the difficulty of orientation in the stomach, and then the interpretation of the findings. Problems of orientation will here be presented as simply as possible, accepting the risk of inevitable oversimplification.

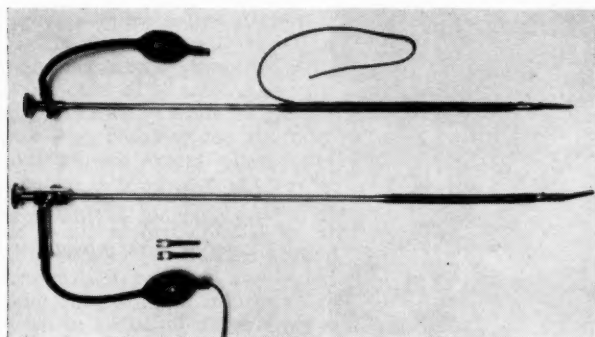


Fig. 1

Top: Schlinder Gastroscope

Bottom: Hermon Taylor  
Gastroscope

If the instrument be passed to its full length and the button on the eyepiece turned to 10 o'clock, the angulus is seen as a curtain over the centre of the field, with the pylorus just visible beyond (see Fig. 4). This may be called Depth 1. Withdrawal to a point where the angulus is just vanishing, brings into view much of the lesser curve and is designated Depth 2. Further withdrawal, until the cardia appears at the opposite pole of the field, and with the button moved to 6 o'clock, is Depth 3. A brief glance at Figures 4, 5 and 6 will make this clear, and will also show that in all but Depth 3, moving the button through 180 deg. will show the corresponding area of the opposite curvature. It will also, however, indicate that there are blind spots as represented on the composite drawing Fig. 7. The blind areas a, b and c, will become visible with the Hermon Taylor instrument with the moveable tip, and the fornix is usually visualised on deep inspiration. Remembering too the fact that the place of the button on the field (usually designated 0 deg.) is proximal, or cephalad, and therefore the point at 180 deg. is distal or caudad, thus enabling one to plot the direction of a peristaltic wave, the first few basic steps in orientation should be achieved.

### Indications

In spite of the quality of diagnostic X-rays, there is still a great place for gastroscopy. Generally one may say there are three broad groups of indications:

1. The presence of symptoms referable to the stomach in which X-rays are normal, e.g., gastritis and stomach neurosis, and haematemesis.

2. When barium meal reveals a lesion about which more information is needed, e.g., "cancer", a polyp, the possibility of a leiomyosarcoma.

3. In the post-operative stomach, e.g., recurrent ulcer, stomal ulcer, and silk erosions.

Gastroscopy is absolutely contraindicated in obstruction to the oesophagus or cardia, and aneurysm of the descending aorta; and should be performed under general anaesthesia in the un-cooperative patient. Pharyngeal inflammation, spinal deformity and achalasia represent contraindications in varying degree. Particularly should the beginner be gentle with the achlorhydric female over 45 years. Tanner has shown the morbidity of gastroscopy to be only 1 in 300 (unlike that of oesophagoscopy, which is 1 in 100) or 25 cases in 7,200. Avery Jones *et al.* report a morbidity of 75 in a collected series of 49,000. In most of these complicated cases, the patient was an elderly female, the stomach acid curve low, and in some, cervical osteoarthritis was also present.

### The Normal Stomach

The normal mucosa is a uniform orange red colour, the highlights shining with mucus. The field is criss-crossed with folds and striations which cast shadows to confuse, but with the introduction of air, many of them flatten out and disappear. This is particularly true of the lesser curve and adjacent areas, but the greater curve retains many folds even when fully inflated, and at its most dependent part on the posterior wall in the fundus, there is to be seen the mucus lake. No folds exist to correlate with the well-known "magenstrasse" of the Physio-



Fig. 2

*Introduction of the gastro-  
scope, First movement*

logy Books. In the antrum, folds are absent, the demarcation with the body marked by the unmistakable angulus. This fold does not extend round the whole circumference, but peters out near the greater curve, and from it extend a series of rhythmic waves spreading evenly down the antrum to abut on the pylorus, which closes at that moment with radial folds and often a pouting back of mucosa and a bubble of air from the duodenum escaping back. The wave recedes, and the pylorus again opens out like the opening of a flower, all this occurring in a gently flowing, beautifully graceful movement. The folds in the body are thickest on the posterior wall and greater curve, become a delicate network on the anterior wall, and largely disappear on the lesser curve. It is extremely rare to see peristalsis in the body.

It is interesting that many of these findings are different from the radiological ones, and that each has something to contribute which to the other is denied.

### *The Abnormal Stomach*

Gastroscopy reveals many and varied appearances in anaemia, varices, granulomata, benign tumours and polyps, foreign bodies, and other pathology, but its main value is in the field of gastric ulcer, cancer and the post-operative stomach.

#### *1. Gastric ulcer*

(a) In a case of chronic ulcer the history and site are already known from the textbooks, and emphasis here will be on only gastroscopic findings. The picture in the living is so different from the gastrectomy



Fig. 3

*Introduction of the gastro-  
scope, Completion of third  
movement*

specimen. The ulcer stands out as a white or greyish-white area in a bright orange-red field. The shape is usually round or oval but may on occasion be irregular, and the edge, which should all be seen, is sharply punched. The floor, usually white or greyish, may be brown with blood or contain food particles, and is smooth except when penetration of the pancreas has occurred, in which case it may be faintly lobulated. The depth of the ulcer, while at first difficult to estimate, is of importance. The mucosa around, though occasionally hyperaemic and oedematous, is usually quite normal, and the mucosal folds may show radiation either from spasm or after healing from fibrosis. Of value in diagnosis and in differentiation from cancer, gastroscopy is also of inestimable help in observing healing of an ulcer during medical treatment, and the picture of one ulcer through its phases of healing over several weeks is truly remarkable. It is more accurate than X-ray, it avoids irradiation, and is far cheaper.

(b) In case of bleeding from an acute gastric erosion in a superficial or atrophic (or even hypertrophic) gastritis, endoscopy is of supreme value. These erosions are often multiple, they heal very rapidly with treatment, and bleeding can be catastrophic. Barium meals taken after a few days are normal, and those who believe in X-ray studies in an emergency may be confused by the report "normal stomach", as erosions are rarely seen and gastritis is not a radiological diagnosis: although in this hospital cases of giant hypertrophic gastritis have been picked up by X-ray. Bleeding is recurrent, and the patients, often quite young females, and without a diagnosis, are sooner or later referred for unnecessary surgery. Gastrectomy has a place here only to save life, and the diagnosis should be made early, not only for subsequent management of bleeding episodes, but also for the interim symptoms and treatment of the gastritis. In Avery Jones's classic work on a series of 687 patients with haematemesis, personally treated, 217 had normal X-rays. Gastroscopy was undertaken in a selected number after the bleeding has stopped, usually the third to tenth day after admission. In 65 of these 116 an acute gastric ulcer was seen.

## 2. Carcinoma.

To the endoscopist, gastric carcinoma may be papilliferous, ulcerative, or infiltrative. The papilliferous growth is characteristic to

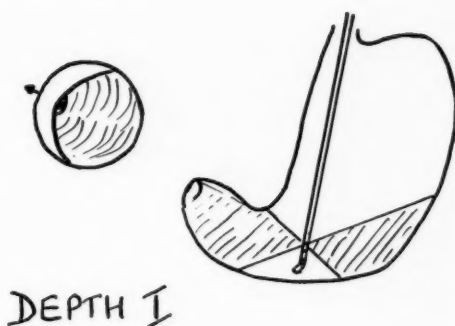


Fig. 4

*Orientation in the stomach: at Depth 1, to show area visualised diagrammatically. Inset shows view with button at 10 o'clock, of incisura and antrum with pylorus.*

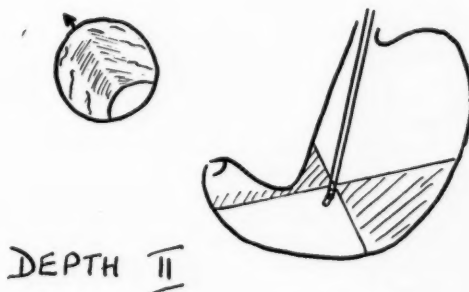


Fig. 5

*Orientation in the stomach: at Depth 2, inset showing view of incisura and lesser curve.*

him and to the radiologist with its broad base, irregular ulcerated bleeding surface, and demarcation from surrounding mucosa. More commonly seen is the ulcerative form, and with this the endoscopist can be dogmatic when a radiologist is in doubt. The position in the stomach may help, but on direct vision the slightest irregularity on the wall at any point with blending infiltration is diagnostic. There may or may not be adjacent mucosal infiltration, but irregularity of an edge, with suspicion of nodularity, or indeed it is safe to say any variation from the punched appearance is diagnostic of carcinoma, though the ingrowing of epithelium in the healing ulcer must be distinguished. Bleeding from the edge as opposed to the base, and the heaped edge, are also diagnostic signs. Most ulcer cancers are unmistakable, but it is the characteristic change in the edge which helps to diagnose even the rare cancer-ex-ulcere. The old adage "when in doubt X-ray again in one month" should never be allowed, any more than prevarication with a breast tumour. In diffuse non-ulcerative infiltrative lesions the case is more difficult. A complete "leather bottle" stomach can be diagnosed even before looking down the instrument by the characteristic resistance to infiltration, with inability to hold air, and noisy eructation. Lesser degrees are diagnosed by areas of pale demarcated mucosa, stiff and motionless, and looking like soggy cardboard with no mucus highlight. Gastritis may be confused with this, and in such a case gastroscopic biopsy forceps may help.

Not only in diagnosis, however, is gastroscopy helpful, but also in planning treatment. The type of tumour, its limits, and therefore the type of incision to make before a radical lower, radical upper, or total gastrectomy is undertaken, are all known, and in contrast to the radiological findings, the extent of surrounding submucosal spread is known with some accuracy. As everywhere else in the bowel, a 5 cm. minimum resection above and below the growth is needed (duodenum excepted) and a preoperative knowledge of the need for a thoraco-abdominal approach is of great value.

### 3. The post-operative stomach.

After gastrectomy or gastroenterostomy, carcinoma and recurrent gastric ulcer and haematemesis present the same problem as in the intact viscus. But the problem of stomal or anastomotic ulcer is peculiar, and

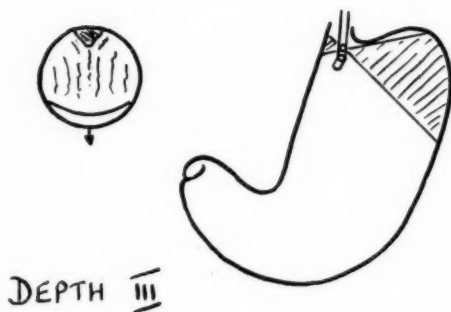


Fig. 6

*Orientation in stomach: at Depth 3, inset showing view of incisura cardiaca and upper part of greater curve with the mucus lake, the button at 6 o'clock.*

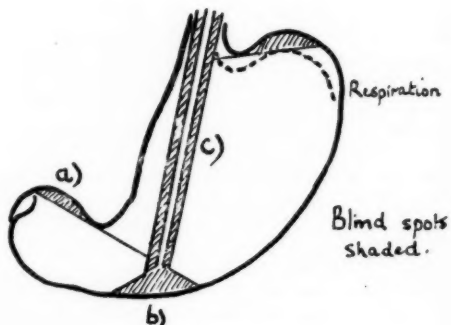


Fig. 7

*Composite diagram of stomach showing blind areas of the Schlinder gastroscope. These are seen using the Taylor instrument.*



X-rays in the diagnosis are notoriously difficult to interpret and may be misleading. While the history and sometimes the findings on fractional test meal are of great help, the ulcer is often diagnosed with certainty only by the gastroscope. These ulcers are frequently recurrent rather than chronic, and frequently bleed, and failure to diagnose by direct vision leads to delay before X-ray examination, and consequent healing during the interval. The practice, now almost universally abandoned, of using silk in the anastomosis led to many "silk" ulcers, and the threads of silk could be seen in the erosion. At one time these were so common that my former chief, Mr. Norman Tanner, invented an attachment like a biopsy forcep to the gastroscope for removal of the silk, healing then being rapidly achieved.

In conclusion one would like to say that the gastroscope is in no sense a rival to diagnostic X-rays. Each has a great part to play in the diagnosis and management of gastric disease, and with the increase in quality of X-ray practice the gastroscope has been

left a little in the shade of popular acclaim. However, the quality of X-rays varies a great deal in different hospitals, and even in the best there are a great many patients haunting clinics with "dyspepsia" as the diagnosis. Many of these could be labelled more accurately if the gastroscope were more widely used.

I should like to take the opportunity of expressing my thanks to three of my Chiefs: to Mr. Hosford for initiating me into the realm of gastroenterology; to Mr. Tanner for teaching me the way amid its intricacies; and to Mr. Hunt for his continued advice and encouragement in this field. I should also like to thank Mr. Harrison and the Photographic Department for their help with the diagrams and pictures.

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## LETTER TO THE EDITOR

### TO OLD BART'S MEN

Dear Sir,

May I appeal through your columns to any Bart's man who might wish to get rid of any old edition of **Rose and Carless's Manual of Surgery**? I am making a collection of these old editions, and those which I still hope to acquire are:—

1st—8th editions (1898-1911)  
 12th edition (1927)  
 16th edition (1940)

The very early ones are only likely to exist in the bookshelves of very early Bart's men, but the two later ones would be equally acceptable to me.

Yours faithfully  
 MICHAEL HARMER

31, Queens Gate,  
 London, S.W.7.

*A review of Rose and Carless's Manual of Surgery appears on page 268. Ed.*

## BOOK REVIEWS

**STROKE, A DIARY OF RECOVERY—** by

Douglas Ritchie. (Faber & Faber, 1960.  
12s. 6d.

It was the prospect of a long railway journey that made me agree to read Douglas Ritchie's book. As Colonel Britton he became a well-known broadcaster during the war. In the prime of life he sustained a cerebral vascular accident involving his dominant hemisphere. This book is the diary of his adaptation to aphasia and a hemiplegia. It takes about two hours to read.

From the security of our health we tend to obscurantism. We regard the introspective excursions of patients in publishing an account of their diseases with suspicion. Then we succeed in dispelling our alarm by thinking with distaste about self-pity or some similar quality. When I had completed this book I still felt it was off the same press as 'Living with Cancer'—and on the surface that impression is probably correct.

Even a rejected experience modifies our thought. From our self-protective isolation we too frequently fail to project ourselves into a patient's mind. Since I read this book my approach has altered. I used to pigeonhole a patient as having had a stroke, and thereafter I stopped thinking. I quailed at the prospect of trying to penetrate the hemiplegic's mind. I now find myself involuntarily recalling Ritchie's experience and endeavouring to apply it. Our knowledge of pathology is so small a part of what a disease means to the patient. It is in the hope that your insight into a common disorder may also be developed that I would recommend this book.

P.W.

**CURRENT MEDICINE AND DRUGS. Vol 1.**

No. 1. Butterworths. Price 1s 3d.

Whether this journal has been produced as an aid to general practitioners or hospital staff or even both is not apparent but it falls below any of these objectives. The articles are too remote for general practice and are not well produced scientific papers that will tolerate exhaustive critical analysis or make any significant contribution to academic medicine. There is one excellent article written from extensive experience on the use of drugs in terminal neoplastic disease—a subject which concerns us all and in which most doctors are ill-informed. Professor Robb's article on anticoagulants in surgical disorders can be of no real value in practice and is scarcely current news in surgical centres.

The other articles are neither helpful nor original since they reiterate well-known and universally practised measures. The section devoted to new drugs is entirely concerned with proprietary products and makes no mention of the pharmacological action, the mode of excretion, the price or the approved names, all of which are of real use in a journal of this sort.

M.L.P.

**ROSE AND CARLESS, MANUAL OF SURGERY—**pp. 1389. Published by Baillière,

Tindall & Cox. Price 84s.

This is the nineteenth edition of one of the oldest manuals of surgery which is in use today. This is itself a great tribute to the book. This edition is not merely one which has been brought up to date. The revision for it has entailed very extensive re-writing under a consulting editor (Sir Cecil Wakeley) and two editors (Michael Harmer and Selwyn Taylor) who have called on 15 contributors—all experts in their own fields.

The seven sections are most conveniently arranged according to anatomical sites. In each section the subheadings are clearly set out for the student to follow. The completeness of the book leads to a good appreciation of the methods of examination, operative procedures and complications. The first section is an excellent study of general considerations which include very useful chapters on fluid balance, blood transfusion, and chemotherapy.

Many of the illustrations which have come to be known as "old favourites" are retained and in addition 370 new illustrations have been included. Throughout the book the illustrations (so important in a work of this kind) are of a very high standard and the diagrams are lucidly simple.

The scope is sufficient to attract those who are studying for the final F.R.C.S. The logical approach is excellent for a good grounding in a subject which is advancing rapidly. As an up-to-date-book it is probably unsurpassed in its field and is a very sound investment.

**"ON THE CAUSATION OF VARICOSE VEINS, THEIR PREVENTION AND ARREST BY NATURAL MEANS",** by

T. L. Cleave, M.R.C.P., Bristol: John Wright and Sons Ltd., 1960, 39 pp., price 7s. 6d.

Surgeon Captain Cleave argues that the body is built rightly, but is being used wrongly. "It must occur to anyone as highly significant that, except for those varices due to known specific causes (e.g. oesophageal varices in cirrhosis of the liver), all varices are confined to those limited areas of the body where pressure from the colonic contents can account for them." Westernized eating habits lead to an unnatural delay in the passage of the colonic contents, with water absorption leading to an unnatural increase in the weight of the contents. Varicose veins, varicoele, and femoral vein thrombosis, as well as piles, may then result. Colonic stasis can be corrected by the restitution of fibre to the food, such as the avoidance of white flour by eating true wholemeal flour, or by the addition of bran. Refined sugar should be substituted by fruits and vegetables.

**HYPNOSIS — FACT and FICTION —** by  
F. L. Marcuse. Published by Penguin Books  
Ltd. Price 3s. 6d.

This book was written in an attempt to answer the questions which more than 1000 people asked the author about hypnosis. This material, together with certain more specialised and less widely known problems have been combined into an excellent little book.

The author has covered topics ranging from historical attitudes to scientific theories; from methods of hypnosis induction to quackery; from its dangers to its therapeutic uses and potentialities. His terms are always clearly defined, but in a few instances, his arguments appear slightly obscure to the uninitiated.

In the preface Dr. Marcuse states that "the aim of this book is simply to separate fiction from fact in the field of hypnosis." This object has been fulfilled in a most comprehensive and convincing manner. It is a book which may be read with profit, both by students as a supplement to the course in psychiatry, and by the merely curious.

S.M.W.

**BIOCHEMISTRY FOR MEDICAL STUDENTS**  
—by W. V. Thorpe. Published by J. & A. Churchill  
Ltd. Seventh edition. pp. 552. Price 30s.

Previous editions of this book have been a standard for medical students for many years. It is a good introduction to the 2nd M.B. course and possibly adequate for passing the examination but the student wishing to see his name in lights would have to undertake a lot of supplementary reading.

The author has attempted to include chemical pathology and some of the chemical aspects of physiology within this compact book so that it looks as if more ground is covered than is in fact the case. There are four photographic plates all dealing with chemical pathology including the famous photograph of the three types of osazone crystals whose shapes have to be memorised by the poor student so that he can distinguish glucose from lactose or maltose in the practical examination. He can draw consolation from the fact that this will be the first and last time he will ever have to identify sugars by that method. I have found no mention of chromatography anywhere in the book.

The earliest chapters introducing physical concepts in biochemistry are too brief and will probably not help students who have absorbed the elements of physical chemistry at school. The intermediate chapters on structure and metabolism in biochemistry have been more extensively revised since the last edition in 1955 though the interesting work on the synthesis of porphyrins is not mentioned, nor the discoveries on the pathway of cholesterol biosynthesis with its direct relevance to the formation of atheroma.

The presentation of the book is genial and it is written in a rather informal style which is easy to read and is punctuated by interesting though somewhat irrelevant information (p. 19. The water content of the mouse at different stages of development). This book will be used by many students for 2nd M.B. and is very reasonably priced but

other books of reference should be consulted at the same time.

J. C. C.

**FRACTURES, DISLOCATIONS and SPRAINS.**  
—by Philip Wiles. pp. 67, 519 illustrations.  
Published by J. & A. Churchill Ltd. Price  
27s. 6d.

This book is an attempt to bring a series of display cards which the author has used in teaching at his own hospital to a wider audience. Although this is the first time that it has been published, the material of the book has been tested over a number of years. The form of the page is attractive. Each fracture is dealt with on a single page according to a fairly rigid formula. A representative series of X-rays is followed by illustrative line diagrams. The text considers the mechanism of the fracture, its treatment and complications under separate headings. Through the book there is a conservative rather than operative approach to treatment. Although the text is dogmatic (largely through its brevity) the student is given a sound framework. This naturally needs augmentation by further reading. There is a surprising lack of post-reduction films which would show the student the degree of displacement and mal-alignment which is acceptable. The book is very pleasingly arranged and has some well reproduced X-rays. It is to be recommended as an excellent approach to a new subject and the modern presentation will help the student to grasp the essentials of the subject with the minimum of effort.

**PHYSICAL SIGNS IN CLINICAL SURGERY—**  
by Hamilton Bailey. pp. 928. Published by  
John Wright & Sons Ltd. Price 75s.

Almost every medical student must have used "Physical Signs" and now we have the thirteenth edition. Originally published in 1927, this work has come to be an invaluable aid in examination and diagnosis. Until this edition the book has been much smaller, but now the scope has been increased. In some ways this is a pity for the student will perhaps be daunted by the length of the book in addition to a systematic manual which he will feel bound to read.

What cannot be denied, however, is the excellence of this edition. The book contains the most remarkable series of pictures which demonstrate the signs which are important in reaching a diagnosis. The present extended volume will undoubtedly appeal to many who have qualified.

In addition to the signs in general surgery, there is a very valuable demonstration of the signs which are important in the special branches. This means that within one cover the student can have a complete record of the signs which are important for him to know not only for his exams but for his proper practice of clinical surgery.

The book is well produced and is an excellent companion to both surgical manuals and clinical study. As in the past, students will find this book an essential aid to their studies in this field. The new edition is very complete and contains a very careful selection of important signs.

## SPORTS NEWS

### Viewpoint

**I**F the normal printing delay takes place, this Journal should be published soon after the new University year starts, and we will have amongst us many prospective athletes. We bid them all welcome, and hope that they will not consider their work at the Hospital is sufficient to stop them taking part in any activities. The staff in the Hospital departments both clinical and preclinical, on the whole, feel that all students should show an active interest in at least one Hospital sport, since no doubt a fit body leads to an active mind. Even when involved in the very strenuous and condensed 2nd M.B. course, it is considered that time should be found for athletic activities at least once a week.

The summer season is now almost over, at the time of writing. The Cricket Club has, unfortunately, lost its semi-final cup match v. St. Georges, after a replay. The batting appears to have let the side down, although the wicket was distinctly tricky early on. The Cricket Club's record this season has been much improved on past years, in fact the best since 1948. This is due to a large extent to the very able leadership of the captain, A. C. Warr, and to his batting. He scored three centuries during the season, with an average of 41, a very fine achievement. Three other players also scored centuries during the season.

### Cricket Club

#### Sussex Tour, July 31st—August 5th.

For the first time for many years we were able to take a strong side on tour, and, as if to register approval the usually bashful English sun shone in her full glory for the whole week. Of the six games played, five were won and one lost. The cricket was always enjoyable and on occasions very amusing. Warr, Walker and Harvey all scored centuries, and most of the other batsmen got after runs. Of the bowlers Garrod and Harvey bowled very well in all the games, and Stoodley had a fine spell at Bancombe. The hospitality of our Sussex friends was as generous as ever, and the whole week was so enjoyed by everyone that it is difficult to single out the highlight of the tour. Was it Archie Warr's stroke-making or Hugh

Walker's whirlwind batting? Was it John Harvey's delightful century or perhaps the Rock'n'Roll session at the Deane Hotel at 2 a.m? On further consideration it will be generally agreed that it was the moment when Padfield awoke from an alcoholic stupor to dismiss "Nobbie" Clarke, a former county batsman, with a brilliant one-handed catch on the fine leg boundary.

#### RESULTS:

*Sunday, July 31st, v. Mariners. Won by 62 runs.*  
St. Bart's 251 for 4 dec. (Warr 103 not out; Davies 40; Walker 48).

*Mariners 189 (Davies 4 for 42; Harvey 3 for 44; Walker 3 for 33).*

*Monday, August 1st, v. St. Andrews. Won by 83 runs.*

St. Bart's 211 for 9 dec. (Davies 50; Pagan 38).

St. Andrews 128 (Stoodley 3 for 28).

*Tuesday, August 2nd, v. Rottingdean. Lost by 7 wickets.*

St. Bart's 80 (Harvey 23).

Rottingdean 81 for 3 (Stoodley 2 for 23).

*Wednesday, August 3rd, v. Ditchling. Won by 49 runs.*

St. Bart's 122 for 8 dec. (Stoodley 23 not out; Jeffreys 21).

Ditchling 73 (Stoodley 3 for 30).

*Thursday, August 4th, v. Bancombe. Won by 127 runs.*

St. Bart's 249 for 8 dec. (Walker 104; Harvey 39).

*Friday, August 5th, v. Newhaven. Won by 152 runs.*

Bancombe 122 (Stoodley 4 for 17; Merry 3 for 28).

St. Bart's 234 for 6 dec. (Harvey 101 not out; Warr 62).

Newhaven 82 (Garrod 6 for 32; Harvey 2 for 6).

#### U. H. Cup Semi-final v. St. Georges, Friday, August 19.—Match Drawn.

Bart's were put into bat on an easy wicket and scored slowly but steadily. Warr scored his third century of the season for the Hospital, and even if this innings was not chanceless it contained many wonderful strokes. None of the other early batsmen made many, and it was left for the tail to add an air of respectability to the score. St. George's were left 160 minutes in which to make the runs but soon fell behind the clock. Garrod and Stoodley provided a hostile opening attack, and Niven and Harvey also bowled very well, but were able to take only 6 wickets by the close.

St. Bart's 213 (A. C. Warr 112, B. J. Stoodley 25).

St. Georges 124 for 6 (J. Rankin 40; J. A. Garrod 2 for 18).

**1st. XI v. Bromley**, Sunday, August 14th. At Bromley.—Won by 4 wkts.

On a dull damp day Bart's won the toss and took the field under the leadership of J. J. Davies. After two bad overs Garrod and Stoodley bowled steadily and four wickets fell for 48 runs; however, a slight recovery occurred and Bromley eventually reached 112. Bart's missed three "run outs" due to narcolepsy in some of the fielders.

Bart's had over two hours in which to bat but lost Davies early. Jeffreys batted well but was fourth out when the score was 59. Harvey and Savage then took the score to 85. At 94-6 Geach joined Harvey and this pair knocked off the runs. A word of thanks is due to A. R. Geach, our most regular scorer.

Bromley 112 (P. A. R. Niven 4 for 9; B. J. Stoodley 3 for 33).

St. Bart's 113 for 6 (R. V. Jeffreys 32; J. A. Harvey 48 not out).

**1st XI v. Ferring**, Saturday, August 20th. At Ferring, Sussex.—Lost by 3 wkts.

After numerous adventures on our way down to Ferring, we won the toss and batted first. Having lost the first two wickets before a run had been scored, Jailler and Jeffreys both batted very well and almost repaired the situation. However, after these two were out no one else made many and we were eventually all out for 113. Ferring started

their innings shakily and, despite a notable lack of support from his fielders, Harvey bowled very well throughout the innings and with a little help from Merry at the other end managed to make them struggle hard for their victory.

St. Bart's 113 (J. M. Jailler 34; R. V. Jeffreys 20).

Ferring 114 for 7 (J. A. Harvey 4 for 36; R. T. E. Merry 3 for 53).

**Cup Semi-final v. St. George's (Replay)** Wednesday, August 24th.—Lost by 5 wkts.

We were again put in to bat, but this time on a very green wicket which quickly became churned up. Warr once again batted very well, but apart from Jeffreys, who fought bravely, the rest of the side gave him little support. We were eventually dismissed for 106. Garrod and Niven opened the bowling and although the George's batsmen were in continual trouble on the treacherous pitch it was not until their total had reached 60 that we were able to break through. Garrod and Harvey then bowled very well and were supported by keen fielding: at one stage it looked as though they were going to run through the opposition, but 106 proved too small a total and we eventually lost by 5 wickets.

St. Bart's 106 (A. C. Warr 46).

St. George's 107 for 5 (J. A. Garrod 3 for 40).

### BATTING AVERAGES

	Inns.	Runs	H.S.	Average
A. C. Warr ...	24	861	112	41.00
J. A. Harvey ...	26	616	101*	32.42
B. J. Stoodley	12	191	49*	31.83
H. R. J. Walker	14	309	104	30.90
W. H. Pagan ...	18	426	59	26.62
J. D. Davies ...	25	537	76	23.35
R. T. G. Merry	26	570	109	22.80
R. V. Jeffreys	26	461	46	19.21
J. M. Jailler ...	16	176	44	14.66

\*Not out

Played 30      Won 13      Lost 5      Drawn 12

### BOWLING AVERAGES

	Overs	Mds.	Runs	Wkts.	Avg.
J. A. Garrod ...	198.1	60	484	37	13.08
B. J. Stoodley	141.1	34	407	29	14.04
J. D. Davies ...	113.4	34	260	17	15.29
J. A. Harvey ...	340	72	963	61	15.78
P. A. R. Niven	203	31	731	35	20.88
R. G. T. Merry	131	22	443	21	21.09
H. R. J. Walker	53.5	6	259	10	25.90

## INTER-FIRM SIX-A-SIDE

Saturday July 23

The rain held off, the day was warm, and everyone who was optimistic enough to come down to Chislehurst had a most enjoyable day. After some very close and exciting preliminary rounds in which a good deal of amusement was caused by the original tactics of certain teams, Kids and

Specials just managed to beat M.O.P.'s and S.O.P.'s in the final. In the evening a dance was held in the pavilion and proved as enjoyable as ever. Our deepest thanks to Mr. and Mrs. White for all the work they put in to ensure the success of the day.

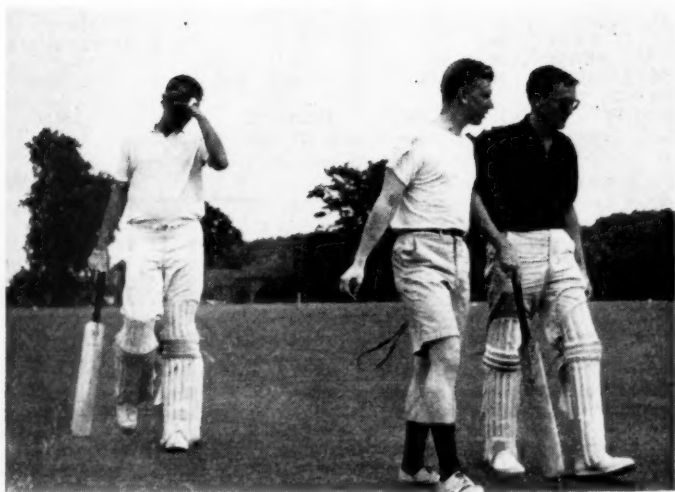




*The Amazons . . .*

*At the Six-a-Sides*

*The Americans . . .*



## Lawn Tennis Club

This season has of course been seriously affected by the continued adverse weather conditions, and in July matches against West Neath, Westminster Hospital, Stonyhurst Wanderers, and Roehampton had to be cancelled. For the same reason our second round Cup Match with St. George's was postponed so many times that they eventually sportingly conceded it to us, then the organisations threatened to scratch us both. This may seem strange to those who realise that they beat us 5-4 on June 18th. but on that occasion Peter Poore was the sole member of the first six playing.

### Mixed Tournament, Sunday, June 26th.

Eight couples turned up and spent an enjoyable afternoon at Chislehurst playing a round robin system. David Latham and Pamela Aldis emerged clear winners.

### v. Epsom College (A), Wednesday, July 6th.

On a dark windy day we just managed to avoid defeat by the college team weakened by examinations. Poore and Perry left one rubber at one set all to avoid holding up the match, and a late rally by Jennings and Bhagit from 2-8 down in the deciding set of the last match saved defeat. Drawn 4-4.

**Team:** M. C. Jennings (Capt.), B. Bhagit, D. Latham, R. Courtenay-Evans, P. D. Poore, M. Perry.

### v. King's College Hospital (A), Saturday, July 16th.

Unfortunately Colin McNeill was misinformed that the match was cancelled and stayed up in Petersborough whilst the remaining five went down heavily to strong opposition. Lost 1-8.

**Team:** D. Latham, R. Courtenay-Evans, D. Prosser, R. Robertson, P. Poore, (C. A. McNeill).

### v. St. Thomas's Hospital (H), Saturday, July 23rd.

Both sides had difficulty in scraping together six players, and the result of a sociable afternoon's tennis was 5-4 in our favour. McNeill and Prosser did well to beat their first pair.

**Team:** C. A. McNeill (Capt.), D. Prosser, M. C. Jennings, P. D. Poore, R. Robertson, D. Glover.

### v. University College Hospital, Wednesday, July 27th.

We could only produce four players, and Bob Robertson was recruited straight from Theatre D. Our opponents arrived by car an hour before us, and Colin McNeill was further held up in some suede-boot shop. Eventually we started playing in a light drizzle which luckily soon stopped and the match ended in a draw. McNeill and Poore won both their rubbers in straight sets, while Jennings and Robertson lost both theirs in three sets.

**Team:** C. A. McNeill (Capt.), P. D. Poore, M. C. Jennings, R. Robertson.

### Cup Match v. Guy's Hospital (H), Saturday, July 13th.

Unfortunately Trevor Seaton, who is a House Physician at the Metropolitan Hospital, came all the way down to Chislehurst only to be called

straight back again to attend to a series of major crises. This gave three rubbers to Guy's and with their first pair on top form they were obviously unbeatable. Latham and Kohli did well to beat their second pair in three sets.

It was a great disappointment to be subdued so easily, because apart from their first pair they were not as good as in previous years. We wish them all the best for the final against St. Thomas's.

**Team:** A. T. Seaton, M. C. Jennings, C. A. McNeill (Capt.), P. D. Poore, D. Latham, S. Kohli.

### v. Nurses, Saturday August 20th.

A very enjoyable match played against excellent opposition on the grass courts at Chislehurst with the men just emerging victorious by 3 rubbers to 1. The ladies were improving all the time and were getting very dangerous indeed when bad light stopped play.

**Men's Team:** M. C. Jennings, P. D. Poore, R. Courtenay-Evans, P. Butler.

**Nurse's Team:** Miss H. Jolly, Miss P. Roberts, Miss P. Willoughby, Miss D. Torhurst.

## Ladies Lawn Tennis

This season we had been offered an unusually large number of fixtures extending into August and including quite a few for a second team. We looked forward to the season with mixed feelings; on the one hand we were losing half of our first team i.e. Jean Arnold, Jennifer Hartley and Janice Swallow, and on the other hand we waited expectantly for our newcomers. The trials had to be held on April 27th at College Hall as the Chislehurst courts were so heavily booked. This was unavoidably soon after the pre-clinicals returned from vacation, and probably accounted for the poor response. Only four new people arrived including two physiotherapists whom we were very pleased to welcome.

### Sat. April 30th 1st VI v. U.C.H. (H) Won 5-3

**Team:** P. Kieley (Capt.), S. Whitaker, A. Vartan, P. Aldis, J. Clarke, J. Sykes.

This was our first outing on grass and the Chislehurst courts were really Wimbledonian! The match was very even throughout till Bart's achieved a 5-3 lead. Due to the late hours and failing light, the remaining game was halved. It was a most satisfying beginning to the season.

### Wed. May 4th 1st VI v. U.C. (H) Won 8-1

**Team:** S. Whitaker, J. Hartley, J. Swallow, R. Murray, P. Kieley (Capt.) R. Watters.

The score is not quite a true indication of the play. All the games were very close, most of them going to three sets. Some very good tennis was played by both sides.

**2nd VI v. St Mary's (A) Lost 4-5**

**Team:** D. Layton (Capt.), P. Aldis, J. Clarke, J. Sykes, T. Lopez, W. Saunders.

We were very pleased to be able to put out such a strong team for this match, which was only just lost in the final set of the final game.

**Sun. May 8th University of London Tournament. 1st Round. 1st VI v. King's College 2nd VI (H) Won 5-2**

**Team:** S. Whitaker, J. Hartley, P. Kielty (Capt.), J. Arnold, P. Aldis, D. Layton.

Unfortunately only two couples arrived from King's College, so Bart's had a 3-0 lead from the outset. The remaining four games that were played were very close and it was a pity that two complete teams could not have achieved a more satisfying result. The match was stopped when Bart's established a winning lead of 5-2.

**Wed. May 18th 1st VI v. Guy's (H) Lost 3-6**

**Team:** P. Kielty (Capt.) A. M. Macdonald, J. Arnold, I. Tomkins, P. Aldis, J. Sykes.

The sunny weather inspired some good tennis from both teams. However we were unable to defeat a very good Guy's team and were left rather worried as to the outcome of our future match against them in the United Hospitals Tournament.

**2nd VI v. Royal Holloway College (A) Lost 2-7**

**Team:** R. Murray, F. Rose, D. Layton (Capt.) J. Clarke, T. Lopez, E. Ware.

We were quite pleased with this result as the opposition is always extremely strong at the Women's Colleges. The afternoon's play was unfortunately rather interrupted by rain.

**Wednesday May 25th University of London Tournament. 2nd Round****1st VI v. Westfield College (A) Lost 1½-5½**

**Team:** S. Whitaker, A. M. Macdonald, P. Kielty (Capt.) P. Aldis, D. Layton, J. Sykes.

This match was rather more exciting than the score suggests—the first couple had played 85 games and the second couple 66 games before Westfield established a winning lead. It was an extremely hot afternoon so we halved the remaining match in play and went thankfully for refreshments.

We wish Westfield luck in the rest of the Tournament.

**2nd VI v. Bedford (A) Lost 2-7**

**Team:** A. Vartan (Capt.), E. Knight, S. Cotton, J. Clarke, T. Lopez, S. Minns.

Though they did not win the second team enjoyed themselves in the glades of Regent's Park and had a pleasant afternoon's tennis. After the first three matches—they unfortunately only had time to decide the remaining sets in one long set each.

**Wednesday June 1st United Hospitals Tournament. 2nd Round. 1st VI v. London (H) Won 7-2**

**Team:** S. Whitaker, J. Hartley, P. Kielty (Capt.), P. Aldis, D. Layton, J. Angell-James.

The first and second couples won their first two matches to give Bart's a comfortable lead of 4-2 at the tea interval. Afterwards this lead was increased to a final 7-2. As it was a very pleasant afternoon, all the matches were played off after the winning lead was established.

**Saturday June 11th United Hospitals Tournament. Semi-Final. 1st VI v. Guy's (H) Lost 4-5**

**Team:** A. M. Macdonald, S. Whitaker, P. Kielty (Capt.), J. Swallow, D. Layton, A. Vartan.

This match was more keenly played than the previous friendly encounter in May. After the first round the score was 2-1 in Bart's favour then at the tea interval it was 3 all and very tense. However our first couple had lost to Guy's second couple, so it now required our second couple to defeat Guy's first couple after tea. As forecast this was the deciding match—a rather tired second couple lost in the final set 4-6, 7-1, 1-6, having played 80 games throughout the afternoon.

We wish Guy's all the best in the final!

On behalf of the team I should like to say how pleased we were to see our Vice-President Dr. Lehmann, on this occasion. He gave us no end of encouragement from the sidelines and a wonderful surprise of strawberries and cream for tea. Thank you very much, Sir!

**Saturday July 2nd 1st VI v. London (A) Won 5½-3½**

**Team:** J. Swallow, J. Sykes, D. Layton, J. Clarke, A. Vartan (Capt.), A. Sinclair.

The London Hospital produced a team after some persuasion, as their normal players were not available so the match was a social occasion rather than a serious afternoon's tennis. The third couples abandoned their first match after two very long sets to avoid holding up the others and the final outcome was a win for Bart's.

**Saturday July 16th 1st VI v. Royal Free (H) Lost 4-5**

**Team:** S. Whitaker, A. Vartan (Capt.), D. Layton, E. Ware, M. Goodchild, S. Watkins.

Bart's with a somewhat unorthodox team came very near to winning the match. The first couple were undefeated and the second couple beat the Royal Free third, but the Royal Free second couple proved their superiority in the decisive set by defeating Bart's third couple 8-6.

**Wednesday August 3rd 1st VI v. West Heath L.T.C. (A) Lost 2-5**

**Team:** P. Kielty (Capt.), S. Whitaker, A. Vartan, E. Knight, D. Layton, M. Goodchild.

This was an evening match so it was decided to play two short sets against each couple. Bart's first and second couples managed 1 set all against their opposite numbers but all the other sets went to West Heath who had a very good team. The match was finished by twilight, then we were entertained to a marvellous supper.

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### FOR SALE

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